Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ELITE HEALTHCARE FORT WORTH
PO BOX 1353
FRISCO TX 75034

Respondent Name
Indemnity Insurance Co of North

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-13-3021-01

MFDR Date Received
July 15, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Theses bills were previously submitted in a timely manner. Please review the attached documentation and pay according to the TDI guidelines."

Amount in Dispute: $461.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…no reimbursement should be ordered to Requestor for the dates of service in dispute."

Response Submitted by: DOWNS & STANFORD, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 21, 2013 April 16-17, 2013	Professional Services	$461.87	$275.70

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.403, titled Medical Fee Guideline for Professional Services, sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150 – Payer deems the information submitted does not support this level of service.
   - 18 – Duplicate claim/service
   - 59 – Processed based on multiple or concurrent procedure rules

Issues

1. Did the submitted medical bill support level of service billed?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing, reporting and reimbursement of professional medical services. Texas Workers' Compensation system participants shall apply the following; (1) Medicare payment policies, including its coding; billing; … and other payment policies in effect on the date a service is provided…" The submitted charge, (99204) is described in AMA CPT as, "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs." Review of five pages of notes for date of service February 21, 2013 finds the following;
    a. Four areas of the body evaluated: lumbar, hip, cervical and thoracic
    b. Each exam included: range of motion, reflexes, orthopedic test, motor function/muscle testing strength, sensory examination
    c. Plan was documented that included consultation with Medical Doctor, Orthopedic and Psychological
    d. Testing scheduled (FCE)

    The Division concludes the use of 99024 is supported. Review of submitted documentation finds a DWC FORM-73 was completed on 2-21-2013 and the 99080 (73) is supported. Payment is recommended

    The insurance carrier denied 97002 for date of service 4-16-2013 as U792 – "Overlapping evaluation charges on the same date of service." Review of the submitted documentation finds initial physical therapy evaluation is dated 4-16-2013. Carrier's denial is supported. No additional payment can be recommended.

    This insurance carrier denied 99213 for date of service 4-17-2013 as MT04 - Physical Medicine – Chiropractic Services rendered beyond 90 days from DOI and MT06 – Physical Medicine – Chiropractic Services rendered beyond 15 visits since DOI. 28 Texas Administrative Code §134.600(p)(5)(C) details requirements of preauthorization and states that, in pertinent part, "except for the first six visits of physical or occupation therapy following the evaluation when such treatment is rendered with the first two weeks immediately following; (i) the date of injury; or (ii) a surgical intervention previously preauthorized by the insurance carrier. Review of the submitted documentation finds no pre-authorization noted for date of service. Carrier's denial is supported. No additional payment can be recommended.
2. 38 Texas Administrative Code §134.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2013, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare CONV FACT) x Non-Facility Price or;

Code	Date of Service	MAR Calculation	Units	Allowable
99204	February 21, 2013	(54.86 / 34.0376) x $161.75	1	$260.70
99080	February 21, 2013	15.00	1	15.00
97002	April 16, 2013	Not supported	1	
99213	April 17, 2013	Not supported	1	
			Total	$275.70

3. The total allowable for the disputed services is $275.70. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $275.70. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $275.70.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $275.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		December 4, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.